U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 22 December 2006

In the Matter of:

C.B.,
Claimant

Case No.: 2005-BLA-05227

v.

McWANE COAL COMPANY,
Employer

and

McWANE COAL COMPANY, INC.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Patrick K. Nakamura, Esq.
Nakamura, Quinn, and Walls
Birmingham, Alabama
For the Claimant

C. Andrew Kitchen, Esq.
Maynard, Cooper, and Gale
Birmingham, Alabama
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled due to pneumoconiosis.

I conducted a hearing on this claim on May 24, 2005, in Birmingham, Alabama. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). At the hearing, the Claimant was the only witness. Transcript ("Tr.") at 10 - 57. Director's Exhibits ("DX") 1-27, Claimant's Exhibits ("CX") 1-4, and Employer's Exhibit ("EX") 1 were admitted into evidence without objection. Tr. at 6 and 8. The record was held open after the hearing to allow the parties to submit closing arguments. The Claimant and the Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at the hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed this, his initial claim, on March 17, 2003. DX 2. The claim was awarded by the District Director of the Office of Workers' Compensation Programs ("OWCP") on June 30, 2004. DX 21. The Employer appealed this decision and requested a formal hearing on July 28, 2004. DX 22. The case was referred to the Office of Administrative Law Judges for hearing on November 9, 2004. DX 25.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, and 718.204 (2006).

ISSUES

The issues contested by the Employer are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

The Employer also reserved its right to challenge the statute and regulations. DX 25; Tr. 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the hearing in Birmingham, Alabama, on May 24, 2005. He was 61 years old at the time of the hearing. Tr. at 21-22. He has a sixth-grade education. DX 2. He has been married to S.B. since 1962. DX 2.

The only coal company the Claimant ever worked for was McWane Coal Company, on the coal washing machinery and as a driller. He began working there between 1975 and 1976 and left in 1983 due to an unresolved strike. DX 2. The parties stipulated to, and I find, 8.5 years of coal mine employment. Tr. at 9. His last coal mine employment was in Alabama. Tr. 36-37; DX 4. Therefore, this claim is governed by the law of the Eleventh Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

As a washer and a driller, the Claimant worked in very dusty conditions. While an employee with McWane, the Claimant testified that he sometimes worked anywhere from 60 to 100 hours per week. He began smoking at age 16, continuing for approximately 40 years at a rate of three packs per day, quitting in 2000 or 2001. Asked about his reports of even heavier smoking to some doctors, he said he sometimes said he smoked five packs a day, but he did not actually smoke that many. Based on the Claimant's testimony and the medical records, I find that the Claimant has a 120 pack year smoking history. The Claimant has been diagnosed by several doctors with several different lung conditions including emphysema and pneumoconiosis. He has had bypass surgery for his heart. He was using supplemental oxygen during the hearing. He said he began using oxygen 24 hours a day after he was examined by Dr. Goldstein in connection with his claim; Dr. Goldstein referred him to his family doctor, Dr. Yates, to check his oxygen levels. Dr. Yates has been treating the Claimant for about 15 years.

Medical Evidence

Biopsies

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. The Benefits Review Board has held,

however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113, 1-114 (1988); *see Dagnan v. Black Diamond Coal Mining Co*., 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that "[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis." There are three biopsy reports in evidence in this case.

A portion of the Claimant's right lung was removed in 1984. The pathology report diagnosed granulomatous inflammation, commenting that there were numerous granulomata. Special stains revealed numerous fungal yeast forms compatible with Cryptococcus. DX 10.

A biopsy of the Claimant's lung was performed on October 7, 2003. DX 11. The microscopic examination revealed fibrosis and "suggested granulomatous change." No tumor was identified.

A CT-guided biopsy of a right middle lobe mass was performed on October 16, 2003. Dr. Quilon from the Pathology Department of Baptist Medical Center – Princeton prepared a report about this biopsy. Her qualifications are not listed, nor does her name appear on the website of the American Board of Medical Specialties. She described the results of the microscopic examination and diagnosis as "hyalinized pulmonary nodule with anthracotic pigment and birefingent crystalline material compatible with anthracosilicotic nodule." The report was reviewed by Dr. Biggs, who is Board-certified in Anatomic and Clinical Pathology. He also viewed the slides and approved the interpretation by Dr. Quilon. DX 10.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who classified opacities observed on x-ray have been obtained where shown in the record by curriculum vitae or other representations. Qualifications of physicians are abbreviated as

follows: B=NIOSH [1] certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
08/16/84			DX 10 Luketic Prominence of the hilar regions and question nodular density adjacent to the right hilum.
08/18/84			DX 10 Luketic Satisfactory post-op chest
11/20/92			DX 11 Sander Right thoracotomy with partial right pneumonectomy; lungs show no acute disease
11/30/95			DX 11 Schiele Emphysema; increased interstitial markings probably represent chronic fibrotic changes but acute interstitial infiltrate cannot be excluded.
12/21/95			DX 11 Schiele Much is illegible but "interstitial changes" and "no significant changes" appear on the report
01/26/96			DX 11 Schiele Increased prominence of interstitial markings and emphysematous changes

[1] The National Institute of Occupational Safety and Health (NIOSH) is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/16/96			DX 11 Roberts Reticular nodular pattern consistent with interstitial lung disease; no acute pulmonary disease
10/21/96			DX 10 Henley Diffuse interstitial disease consistent with emphysema, possibly on the basis of pneumoconiosis.
01/26/96			DX 11 Schiele Emphysematous changes
01/19/02			DX 10 Walker Bilateral chest tubes with no pneumothorax or significant interval change. Mild parenchymal changes persist.
01/24/02			DX 10 Russell Extensive bilateral subcutaneous emphysema. Assessment: Continued bilateral subcutaneous emphysema with interstitial opactification bilaterally, raising question of pneumonia.
01/31/02			DX 10 Underwood Extensive interstitial disease. Possible small bilateral pleural fluid collections. No pneumothorax or changes since 1/20 examination.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/13/03	DX 9 Nath BCR/B ILO Classification 2/2 CX 2 Cappiello BCR/B ILO Classification 2/2		DX 9 Barrett BCR/B Read for quality Quality "1"
06/25/03			DX 11 Bradley COPD; ill defined opacities which could be the result of scarring, pneumonia, neoplasm or the sequelae of silicosis.
10/16/03 2:00 pm			DX 10 Billions No evidence of pneumothorax post biopsy. Postoperative changes with diffuse interstitial thickening.
10/16/03 3:15 pm			DX 10 Billions Nodular changes within the upper lungs. No pneumothorax.
12/19/03	DX 11 Goldstein B ILO Classification 1/1 CX 1 Cappiello BCR/B ILO Classification 2/1 CX 4 Miller BCR/B ILO Classification 3/2, A	EX 1 Wheeler BCR/B ILO Classification 0/1	
01/27/04			DX 11 Westerman, no acute pleural disease

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height[2]**	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 9 06/05/03 Khan	59 73"	0.94 1.12	2.33 2.98	40% 38%	43 49	Yes Yes	Severe obstructive lung disease with impaired diffusion. No response to bronchodilators. Acceptable except for suboptimal MVV perform-ance per Dr. Michos, DX 9.
DX 9 09/05/03 Khan	59 72.5"	0.78 1.03	2.17 2.86	36% 36%	37 47	Yes Yes	Severe obstructive lung disease. Significant response to bronchodilation. Acceptable except for suboptimal MVV perform-ance per Dr. Michos, DX 9.

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). There is a variance in the recorded height of the Miner from 72.5" to 73". As two out of three measured the Claimant at 73", I have taken that figure in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[2]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 11 12/19/03 Goldstein	60 73”	1.09 1.22	2.62 3.08	42% 40%	48	Yes Yes	Moderate to severe obstructive defect with minimal improvement after bronchodilators. Patient unable to continue post study due to dyspnea.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 11	11/20/92	Bush	36	60.4	Yes	
DX 10	01/16/02	Riggins	45	87	No	
DX 9	06/05/03	Khan	39.8 44.1	64.9 57.8	No Yes	Hypoxemia
DX 11	12/19/03	Goldstein	43	51	Yes	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner’s disability.

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to this case.

Treatment Records

The Employer submitted 566 pages of the Claimant's treatment records from Baptist Medical Center-Princeton, covering 1984 to 2003, found in DX 10, and 63 pages of treatment records obtained from Dr. Yates and Dr. Westerman, covering 1992 to 2003, found in DX 11.

Dr. Yates' office notes from February 2, 1992, to May 5, 2001, are in the record. DX 11. Dr. Yates' qualifications are not in the record. Dr. Yates examined the Claimant periodically, and the chest examination was normal in all of these records. A report dated October 16, 1996, gave a diagnosis of chronic obstructive pulmonary disease (COPD) with emphysema, and the chest examination was clear. Additionally, Dr. Yates noted at most of the visits that the Claimant was smoking and encouraged the Claimant to stop.

Dr. Boswell saw the Claimant with complaints of chest pain and numbness in the left side of his body in 1996. DX 11. Dr. Boswell noted a medical history of emphysema and that the Claimant smoked up to five packs per day. The physical examination revealed diminished breath sounds throughout. The Claimant also visited Walker Baptist Medical Center with similar complaints, but left against medical advice after a positive thallium stress test, saying he would follow up with Dr. Yates.

On January 23, 2003, the Claimant was seen by Dr. Brouchard for coronary artery disease (CAD), in follow-up to bypass surgery in January 2002. DX 11. The report noted a history of COPD, emphysema, and a pneumonectomy in 1982. Dr. Brouchard diagnosed CAD and COPD/emphysema..

Dr. Westerman performed a biopsy on the Claimant on October 7, 2003. The results are reported above. He saw the Claimant on December 1, 2003, and January 6, 2004, for follow-up

visits. DX 11. According to the American Board of Medical Specialties,[3] Dr. Westerman is Board-certified in Internal Medicine, Pulmonary Disease, and Critical Care. Dr. Westerman took the Claimant's medical, social, family, and occupational histories. He noted that the Claimant had a 120 pack year history but was not currently smoking. Dr. Westerman found that the Claimant was disabled at the time of the examination. The chest examination revealed bilateral expiratory wheeze and soft anterior rhonchi. Dr. Westerman diagnosed bilateral pulmonary infiltrates, COPD with reactive airway disease (RAD), pneumoconiosis–probable silicosis and coal workers' pneumoconiosis, and history of tobacco abuse.

The significant pulmonary findings in the records from Baptist Medical Center, DX 10, other than biopsy and x-ray results reported above, are outlined in the following table. Many of the records, or parts of the records, were illegible due to poor copies.

Exhibit #/Type of Record/Date	**Physician**	**Diagnosis**
Medical Record 06/16/84	Illegible	Abnormal lung field; emphysema
Operative report 08/17/84	Kessler	Partial resection of the right lobe. -mildly anthracotic -no silicosis
Discharge Summary 08/24/84	Kessler	Thoracotomy and partial resection right lobe. Final diagnosis: Granuloma of the lung (Cryptococcus)
Physical Examination 10/21/96	Cotton	Lung Examination –bilateral basilar dry crackles and rhonchi at the right base. History of COPD, but no wheezing or distress at time of examination.
Emergency Room Report 10/21/96	Illegible	Smoking history of three packs per day.
Emergency Room Report 10/21/96	Shory	History of COPD, smoking 3 packs per day Chest examination was normal.

[3] Information about physician Board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org.

Exhibit #/Type of Record/Date	**Physician**	**Diagnosis**
History and Physical 10/21/96	Bouchard/Cotton/Shory	Presented to emergency department complaining of left sided chest pain. History of COPD; smoking 3 packs per day. Lung examination revealed bilateral basilar dry crackles and rhonchi at the right base.
Operative report 10/22/96	Bouchard	Coronary arteriogram and left ventriculogram. Medical treatment, stop smoking.
Discharge Summary 10/22/96	Bouchard	Cardiac catheterization. Final diagnoses: Unstable angina, History of smoking abuse and COPD.
History and Physical Examination 09/04/97	Fagan	History of COPD with tobacco use. Smoking history of three to fours packs per day.
Preoperative Report 12/06/01	Bouchard	Coronary arteriogram. History of partial pneumonectomy for benign tumor; chronic obstructive pulmonary disease with emphysema from smoking. Stopped smoking eight months ago.
Discharge Summary 12/11/01	Bouchard	Coronary arteriogram and cardiac catheterization. Final diagnoses: CAD; COPD with emphysema; status pos pneumonectomy for benign tumor; past history of smoking abuse
Insurance Summary 12/11/01		Listing diagnostic codes for Emphysema NEC, and Shortness of Breath
Medical Report 12/16/01	Bouchard/Yates	COPD with emphysema from smoking. Stopped smoking 8 months ago. Chest examination revealed decreased breath sounds with prolonged expiratory phase.

Exhibit #/Type of Record/Date	Physician	Diagnosis
Preoperative Report 01/16/02	Riggins	Coronary artery bypass graft. History of COPD with emphysema.
Discharge Report 01/24/02	Davis	Principal diagnosis coronary artery disease. Secondary diagnoses include atrial fibrillation and pneumothorax, and chronic obstructive pulmonary disease.
Insurance summary 01/24/02		Listing a diagnostic code for COPD with acute exacerbation.

Medical Opinions Given in Connection with the Black Lung Claim

Dr. Khan examined the Claimant on behalf of the Department of Labor on June 5, 2003. DX 9. Dr. Khan's qualifications are not in the record and cannot be determined from the website of the American Board of Medical Specialties. Dr. Khan took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for approximately eight years. He reported a smoking history of three packs per day for 41 years. The chest examination was normal. Dr. Khan relied on the reading of the chest x-ray by Dr. Nath as showing coal workers' pneumoconiosis, 2/2, emphysema, and possibly tuberculosis. The pulmonary function test revealed severe obstructive impairment. The arterial blood gas study revealed hypoxemia. Dr. Khan diagnosed coal workers' pneumoconiosis with severe COPD. He based this diagnosis on pulmonary function tests, chest x-rays, and history. Dr. Khan opined that coal dust exposure and cigarette smoking caused the pneumoconiosis with associated COPD. Dr. Khan opined that the Claimant had a significant impairment that would prevent from performing his last coal mine job of one year duration. He attributed this impairment to pneumoconiosis with associated COPD to a "significant extent."

Dr. Khan provided an additional report at the request of the Claimant for the purposes rehabilitation. CX 3. He reviewed his original report, and the report of CT-guided biopsy taken October 16, 1993. He reiterated his understanding that the Claimant worked as a drill operator for eight years, and smoked three packs per day from 1960 to 2001. He opined that the Claimant suffered from COPD and coronary artery disease, which he attributed to the Claimant's smoking history and coal dust exposure. Additionally, Dr. Khan opined that these two conditions contribute to the Claimant's pulmonary impairment. Dr. Khan went on to state:

> I do not think it is possible to assign an exact percentage of contribution of the factors to his COPD; certainly, his smoking history is a major factor in the creation of this disease. However, [the Claimant's] years of exposure to coal dust has damaged his lungs to the point that it is detectable both through biopsy and x-ray. I believe, to a degree of medical certainty that the pneumoconiosis resulting

> from [the Claimant's] years of direct exposure to coal mine dust plays a significant role in either the creation or the exacerbation of the Chronic Obstructive Lung Disease that contributes to his pulmonary impairment.

Dr. Goldstein examined the Claimant on behalf of the Employer on December 19, 2003. DX 11. Dr. Goldstein is Board-certified in Internal Medicine and Pulmonary Disease, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the coal mines for 8.5 years. He reported a smoking history of 2.5 to 3 packs per day for 30 years but has not smoked for the last 3 years. The chest examination revealed hyperresonant with scattered rhonchi and wheezes that do not clear with cough. Dr. Goldstein read the x-ray as showing hyperinflation and infiltrate in both mid to upper lung fields. Dr. Goldstein opined that the infiltrate could be related to previous surgery or could represent pneumoconiosis. He classified the x-ray as 1/1. The pulmonary function test revealed moderate to severe obstructive defect with minimal improvement following bronchodilators. The Claimant's oxygen saturation was low at 87%. Dr. Goldstein diagnosed COPD and congestive heart failure. In addition, he opined that even if the Claimant did suffer from pneumoconiosis, his symptoms were related to cigarette smoking. Dr. Goldstein stated that where a patient's congestive heart failure [sic] is caused by pneumoconiosis, there is associated massive fibrosis, leading to restrictive and obstructive defects. Dr. Goldstein did not find that the chest x-ray showed massive fibrosis. Dr. Goldstein recommended that the Claimant talk to his treating physician about home oxygen. Dr. Goldstein observed in his report that he had not seen the Claimant's old records, and that recent biopsies and as many x-rays as possible would be very helpful.

After reviewing his own report, the records from the Department of Labor examination, and the records from Dr. Yates, Dr. Westerman, and Baptist Medical Center-Princeton, in a supplemental report dated March 2006, DX 10, Dr. Goldstein diagnosed chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure as the cause of the Claimant's shortness of breath. He went on to state,

> … He does not have coal workers' pneumoconiosis nor does he have any disease that is caused by or worsened by his exposure to coal dust.
>
> It is my understanding that [the Claimant] worked in the coal mining industry for less than ten years. Though he was exposed to coal dust and rock dust, the amount of time that he spent in the coal mining industry would be considered to be minimal. In any case, there is no evidence from his records or from my examination that he developed coal workers' pneumoconiosis.

Dr. Russakoff also reviewed the Claimant's medical records from 1984 to 2004, on behalf of the Employer, including Dr. Goldstein's reports, and prepared a report dated May 3, 2004. DX 10. Dr. Russakoff is Board-certified in Internal Medicine and Pulmonary Disease, and a B reader. Dr. Russakoff noted that the Claimant had occupational exposure for 8-9 years in the coal mines. In 1984, when an asymptomatic lung lesion was resected from the right upper lung, there was no mention of pneumoconiosis on chest x-rays or the pathology specimen.

Dr. Russakoff observed that the Claimant's coronary artery disease and obstructive lung disease became apparent in the late 1990's, with chest x-rays suggesting some changes. After coronary bypass grafting in 2002, later x-rays began to show advancing changes on the x-rays. Cancer and infection were ruled out, and the biopsy clearly resulted in a diagnosis of anthracosilicosis. He said the chest x-ray readings limited the extent of the nodular opacities, which were, therefore, unlikely to cause the extent of the Claimant's impairment. Dr. Russakoff went on to state,

> … In view of the findings at his coronary artery surgery, his chest x-ray reports, and his pulmonary function tests, it is clear that [the Claimant] has significant pulmonary emphysema which I believe is related to his 120 pack/year history of cigarette smoking. In addition, it is record that he has evidence of congestive heart failure which also contributes along with his emphysema to his current symptoms of shortness of breath.
>
> While the medical records document the presence of a pneumoconiosis, anthracosilicosis, it is my opinion that this pneumoconiosis is not the cause for his disability. Rather it is my opinion that his disability is related to the far more extensive emphysema and airway obstructive both permanent ad reversible (asthma) that he suffers with related to his cigarette smoking and to his underlying cardiovascular disease also relate to his cigarette smoking.

Report at 5. He went on to respond to specific questions from the Employer's counsel, opining that accumulated evidence of progressive changes on the Claimant's x-rays, along with the lung biopsy report that clearly describes anthracosilicosis, establish that the Claimant has coal workers' pneumoconiosis arising from his coal mine employment. He attributed the Claimant's emphysema entirely to smoking. He also said that the Claimant was totally disabled from a pulmonary standpoint, due to chronic obstructive pulmonary disease and cardiovascular disease due to smoking, and not to coal dust exposure.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis,

anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with coal workers' pneumoconiosis, as well as chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis,[4] the Claimant has less than 15 years of work in coal mines and filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the biopsy reports, chest x-rays, and medical opinions. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has

[4] One dually qualified Radiologist, Dr. Miller, read the December 19, 2003, x-ray to show an "A" sized opacity, which would fall within the definition of complicated pneumoconiosis. However, neither of the other readers of that x-ray diagnosed complicated pneumoconiosis, nor did any of the physicians who provided reports based on examinations of the Claimant or review of his medical records. For this reason, I find that the Claimant has failed to establish that he has complicated pneumoconiosis.

pneumoconiosis. *Island Creek Coal Co. v. Compton Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *see also, U.S. Steel Mining Co. v. Director, OWCP [Jones]*, 386 F.3d 977, 991 (11th Cir. 2004).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Biopsies

Three biopsies were reported in this case. The first, in 1984, revealed only granulomata. Two were taken in 2003. Both biopsies were positive for evidence of fibrosis. Moreover, the third, CT-guided biopsy of a right middle lobe mass disclosed anthracotic pigment, and an anthracosilicotic nodule. Anthracosilicosis is specifically included in the definition of clinical pneumoconiosis. Thus, the recent biopsy evidence supports a finding of pneumoconiosis.

X-rays

The chest x-ray readings available in this case cover the period from 1984 to 2003. Most were taken as part of the Claimant's treatment, and even if they mentioned the presence or possibility of pneumoconiosis, they were not classified as required by the rules. Beginning in 1995, however, the x-rays were consistently read as showing emphysema and interstitial disease.

Two x-rays were read in connection with the black lung claim. The June 13, 2003, x-ray was read as positive for pneumoconiosis by two dually qualified readers. I find this x-ray to be positive.

The December 19, 2003, x-ray was read as positive by one B reader and two dually qualified physicians. This same x-ray was read as negative by one dually qualified physician. As more well-qualified readers found the x-ray to be positive, I find this x-ray to be positive.

Thus, the x-ray evidence also supports a finding of pneumoconiosis.

Medical Opinions

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

The Department of Labor's position underlying the current regulations, stated in the commentary that accompanied their issuance, is that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." Medical opinions which are based on the premise that coal dust-related obstructive disease is completely distinct from smoking-related disease, or that it is never clinically significant, are therefore contrary to the premises underlying the regulations. I have considered how to weigh the conflicting medical opinions in this case based on these principles.

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a Judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the

nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006).

The Claimant's treatment records consistently show diagnoses of COPD and/or emphysema from 1996 on. Much of his treatment between 1996 and 2003 focused on his coronary artery disease, which led to catheterization in 1996 and 2001, and bypass surgery in 2002. In 2003, however, contemporaneously with his pursuit of his black lung claim, the Claimant was referred to a Pulmonologist, Dr. Westerman, who performed a biopsy, and later provided follow-up care. Dr. Westerman diagnosed pneumoconiosis as well as COPD with reactive airway disease. Dr. Westerman's diagnosis is consistent with the objective evidence. I find that Dr. Westerman's opinion is entitled to probative weight on the issue of pneumoconiosis.

Three doctors prepared reports concerning the Claimant's respiratory condition in connection with the black lung claim, Dr. Khan, Dr. Goldstein, and Dr. Russakoff. Dr. Khan performed the DOL sponsored examination. He opined that the Claimant suffered from both clinical and legal pneumoconiosis. He based his opinion on the objective evidence of record and provided his reasoning. Thus, I find his report to be well documented and well reasoned and accord it probative weight on the issues of clinical and legal pneumoconiosis.

Dr. Russakoff reviewed the Claimant's medical records, and found that the Claimant had clinical pneumoconiosis. However, he did not believe that coal dust exposure contributed to the Claimant's disability, which he attributed entirely to cigarette smoking. I find that his report is well documented and reasoned on the issue of clinical pneumoconiosis. However, he offered no explanation as to why he discounted any role for coal dust in the Claimant's obstructive disease. For this reason, I find that his opinion on legal pneumoconiosis is not well reasoned, and give it less weight than Dr. Khan's on the issue of legal pneumoconiosis.

Finally, Dr. Goldstein, who examined the Claimant on behalf of the Employer, opined that the Claimant did not suffer from pneumoconiosis. He initially based his opinion on the objective evidence of record available to him, and provided his reasoning. At the time that he rendered his initial opinion, however, he had not seen the biopsy results. Thus, his opinion that the Claimant did not have clinical pneumoconiosis, based on incomplete information, is entitled to less weight. Moreover, even after he saw Dr. Westerman's and other records, he still said there was "no" evidence that the Claimant has pneumoconiosis. His opinion is not consistent with the objective evidence, and I find it to be unreasoned.

Based on the opinions of Dr. Westerman, Dr. Khan and Dr. Russakoff, I find that the Claimant has established that he has both clinical and legal pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was

employed as a miner for only 8.5 years, and therefore, is not entitled to the presumption. However, the opinions of Dr. Khan and Dr. Russakoff support the conclusion that the Claimant's clinical pneumoconiosis was caused by exposure to coal dust. Moreover, to the extent that the Claimant has legal, as opposed to clinical pneumoconiosis, the causal relationship is established by the opinion of Dr. Khan. I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). I have determined that the evidence does not establish that the Claimant suffers from complicated pneumoconiosis, and there is no evidence in the record that he suffers from cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies, and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204 (b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

Pulmonary Function Studies

All of the pulmonary function studies produced qualifying results. Thus, the pulmonary function studies support a finding of total disability.

Arterial Blood Studies

There are four arterial blood gas studies in the record. The 1992 study produced a qualifying value, but the 2002 study did not. Of the two most recent studies, the first, in June 2003, produced a nonqualifying value at rest, but a qualifying value with exercise, and the second, in December 2003, produced a qualifying value at rest. I find that the study with exercise from June should be credited as showing that the Claimant would be unable to perform exertion; thus, I find that both 2003 tests were qualifying. As the two most recent studies produced qualifying results, I find that the arterial blood gas studies also support a finding of disability.

Medical Opinions

Dr. Goldstein made no finding on the issue of total disability. Thus I will not consider it.

Dr. Khan found that the Claimant suffered a significant pulmonary impairment that would prevent him from performing his last coal mine job. He based his opinion on qualifying pulmonary function studies and arterial blood gas studies. Thus, I find this report well documented and well reasoned, and probative on the issue of total disability. Dr. Russakoff also said that the Claimant was totally disabled from a pulmonary standpoint. The available medical opinion evidence, therefore, supports a finding of total disability.

As all of the pulmonary function studies, and two most recent arterial blood gas studies, are qualifying, the objective testing supports a finding of disability. Additionally, the medical opinions support the conclusion that the Claimant is totally disabled from a pulmonary or respiratory impairment. Thus, I find that the Claimant has established that he is totally disabled by a pulmonary or respiratory impairment.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis was a "substantially contributing cause" to the miner's disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990).

The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit has long required that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the miner has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the miner did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical

> opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also, Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

In this case, Dr. Goldstein opined that the Claimant did not suffer from pneumoconiosis, which is contrary to my overall finding. Nor did he offer any opinion on whether the Claimant was disabled. I need not consider Dr. Goldstein on this issue.

Dr. Khan opined that the Claimant's impairment is attributable to his pneumoconiosis and COPD. Furthermore, Dr. Khan found that the pneumoconiosis and COPD were caused by coal dust exposure. Dr. Khan provided documentation, and his reasoning is consistent with the objective evidence. His opinion is also consistent with the premises underlying the current regulations. For these reasons, I find his report to be well documented and well reasoned on the issue of the cause of the Claimant's disability, and accord it probative weight on this issue as well.

Dr. Russakoff, on the other hand, rejected any role for coal dust exposure in the Claimant's obstructive disease, without any explanation. By denying any role for coal dust, in effect, he found that the Claimant does not suffer from legal pneumoconiosis, which I have found to be present. Dr. Russakoff did not offer any specific and persuasive reasons for concluding that coal dust did not contribute to the Claimant's chronic obstructive pulmonary disease. For this reason, I find that Dr. Russakoff's opinion is entitled to less weight.

The Employer argues that the Claimant underreported his smoking history, and exaggerated his exposure to coal dust. The Employer suggests that the Claimant smoked as much as five packs of cigarettes per day for 50 years. That figure is untenable; the Claimant was only 61 years old at the time of the hearing. Moreover, I have credited the Claimant's explanation that he did not actually smoke five packs per day, despite his occasional statements that he did. Based on all of the evidence, I have found that the Claimant has a 120 pack year history, admittedly a history of very heavy smoking. Nonetheless, this argument by the Employer does not address the additive effect of coal dust exposure to the effects of cigarette smoking.

The Employer also suggests that, based on the Claimant's testimony, he was only exposed to coal dust for one year, when he worked as a washer. However, the Claimant also testified that he was exposed to dust as a driller. Tr. at 15, 17, 20. In any event, the Claimant's perception of how much dust he was exposed to during his coal mine employment is not the determining factor. The fact that the Claimant worked as a miner for eight and one-half years is uncontested, and was known to the physicians who assessed him, as was his very heavy smoking history. The fact that the Claimant developed anthracosilicosis years after he left coal mining suggests that however much dust he was exposed to, it was enough to cause him harm. My determination that exposure to coal dust contributed to the Claimant's obstructive impairment is

based on my evaluation of the medical opinion evidence, not Claimant's speculative estimate of how much dust he was exposed to.

Based upon Dr. Khan's opinion, I find that the Claimant has established that his total disability is due pneumoconiosis.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that he is totally disabled due to pneumoconiosis, and he is therefore entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on March 17, 2003, is hereby GRANTED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).